A reflection on the practical implementation of the clinical governance framework in the Cape Winelands District of the Western Cape

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Primary health care is seen as the 'linchpin of effective health care delivery' by the Western Cape Government Health services and improving the quality of primary care, through clinical governance, is a key aspect of realising this vision. This article aims to provide an outline of the provincial clinical governance framework and to reflect on the experience and lessons learnt within the semi-rural Cape Winelands District in implementing this framework.

Strategies that were used included the establishment of district clinical governance meetings; leadership development of both managers and family physicians, defining clinical governance activities and using routine monitoring and evaluation meetings as part of quality improvement cycles; developing clinicians competent to address the burden of disease; and focusing on establishing a primary health care approach in the district.

Lessons learnt included that activities should take place within a supportive organisational culture with a focus on continuous quality improvement at all levels of the health system. A systematic approach to planning clinical governance at the district level should be balanced with a localised approach to encourage reflection, engagement and change. Recommendations for further implementation of clinical governance in the district are listed.

Keywords: clinical governance, family physician , health care quality, primary health care

Introduction

Primary health care (PHC) is seen as the 'linchpin of effective health care delivery' by the Western Cape Government Health services (WCGH) and the quality of primary care is a key aspect of realising this vision.[1] Clinical governance is defined as 'a framework through which organizations are accountable for continuously improving the quality of their services and safeguarding high standards, through creating an environment in which excellence in clinical care can flourish'.[2] This definition has been adopted by the WCGH, which also focuses on the importance of clinical governance occurring 'continuously, thoughtfully and in a co-ordinated fashion'.[3] This article aims to provide an outline of the WCGH's clinical governance framework and to reflect on the experience and lessons learnt within the Cape Winelands District (CWD) from implementing this framework.

Provincial clinical governance framework

The initial 2009 WCGH clinical governance framework[4] aimed to provide a practical structure for improving the quality of care that was based on the work of Scally and Donaldson.[2] The conceptual framework for clinical governance (Figure 1) had at its core the interaction between a client and healthcare provider and clinical governance was seen as focusing on the technical quality of this interaction. The framework recognised that client satisfaction was in part a result of the technical quality of this interaction, but would also depend on the person's expectations, and their entire experience, of the health care system and facility. It was recognised that burnt out and depressed providers would be impaired in their ability to offer high technical quality and that poor-quality consultations might also contribute to low provider satisfaction. Caring for the carers was, therefore, also seen as an important component.

The framework included a range of health care providers, working at different levels of care in the system, delivering appropriate but different packages of care, and using evidence-based clinical management guidelines. The existence of norms and standards, in the form of accepted clinical guidelines and protocols, and performance management mechanisms, to review the adherence to these protocols, were also described. The regulatory framework for the clinical governance policy is shown in Figure 2.

The regulatory framework (Figure 2) included a section on developing a performance management system for clinical governance, which would guide senior clinicians and managers on the necessary line management systems. 'Line management functionaries' were responsible for ensuring the implementation of improvement strategies suggested by the 'clinical governance functionaries and programme management functionaries'.[4]

Management tools for performance measurement (Figure 2) were identified: use of data on laboratory investigations as a proxy for appropriate clinical assessment; review of drug usage through existing pharmaceutical performance systems as a proxy for appropriate intervention; and, the use of morbidity and mortality meetings as a proxy for appropriate outcomes.

In both the WCGH and CWD discussions it became clear that while there were good clinical guidelines and clear packages of care (Figure 2) to guide the technical quality of the client–
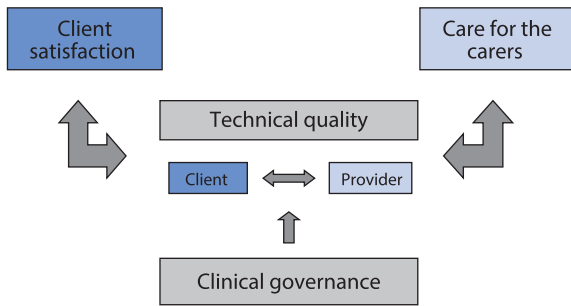
Figure 1: Conceptual framework for clinical governance.[5]

developing a district-specific strategy and an implementation plan for clinical governance'.[6]

Accountability for clinical governance in the district

The CWD, with a population of 826 439,[7] is a 22 000 km² semi-rural area outside Cape Town that was established in 2008 and incorporates five sub-districts. The district is managed by a single health authority, which is the custodian of four district hospitals, a specialised TB hospital and 53 fixed PHC facilities. In three of the sub-districts there are district hospitals, where the FP is the lead clinician, whilst in two of the sub-districts there is a regional hospital where there are general specialists in the major clinical disciplines as well as an FP who is responsible for the PHC services. The management of each sub-district includes a medical manager, PHC manager and FP.
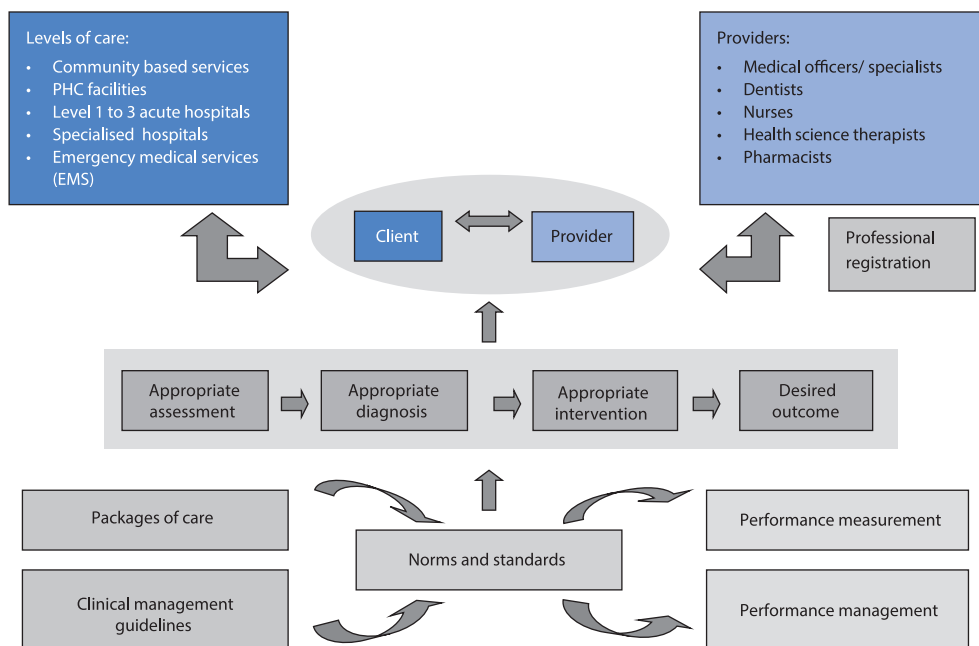

Figure 2: Regulatory framework for clinical governance.[5]

provider consultation, the challenge lay in implementation, which required a whole system approach to change rather than just a focus on the provider, to improve the 'client–provider' interaction in the consulting room.

The final framework was distributed in 2012[5] and various workshops were held to better understand the framework. One of the themes that emerged was the importance of coordination of care and communication amongst clinicians, line managers and policy-makers. Various structures were established to enable this, such as geographic service area (GSA) meetings and provincial clinical governance committees.[5] The GSA meetings brought together the relevant clinical and managerial role players responsible for services in a specific area — initially the geographic area served by a regional hospital. Provincial clinical governance committees brought together all the role players concerned for the quality of care in a specialist discipline such as internal medicine, paediatrics, or obstetrics and gynaecology. The clinical governance committees each included a family physician (FP). In line with the National Development Plan, the FP was seen as having the 'the primary responsibility for

The initial WCGH's district management accountability framework had four pillars as shown in Figure 3. The two pillars that relate to clinical governance are 'governance' and 'quality' with the corresponding sections of 'leadership' and 'improving the quality of services'. The pillar on governance has clinical governance as one of three main components and this refers to the managers and management structures responsible for clinical governance within the district and described in the clinical governance framework above. The pillar on quality improvement is split into two main components, compliance with norms and standards for health facilities that are set out nationally in seven domains, and attention to the patient's experience of the health services, particularly in terms of reception, clinical care and continuity. One of the domains under the national norms and standards also speaks to requirements for clinical governance. In the district management team, a quality assurance manager is appointed with a specific responsibility for norms, standards and patient experience, whilst the FP is responsible for leading clinical governance activities under the first pillar.
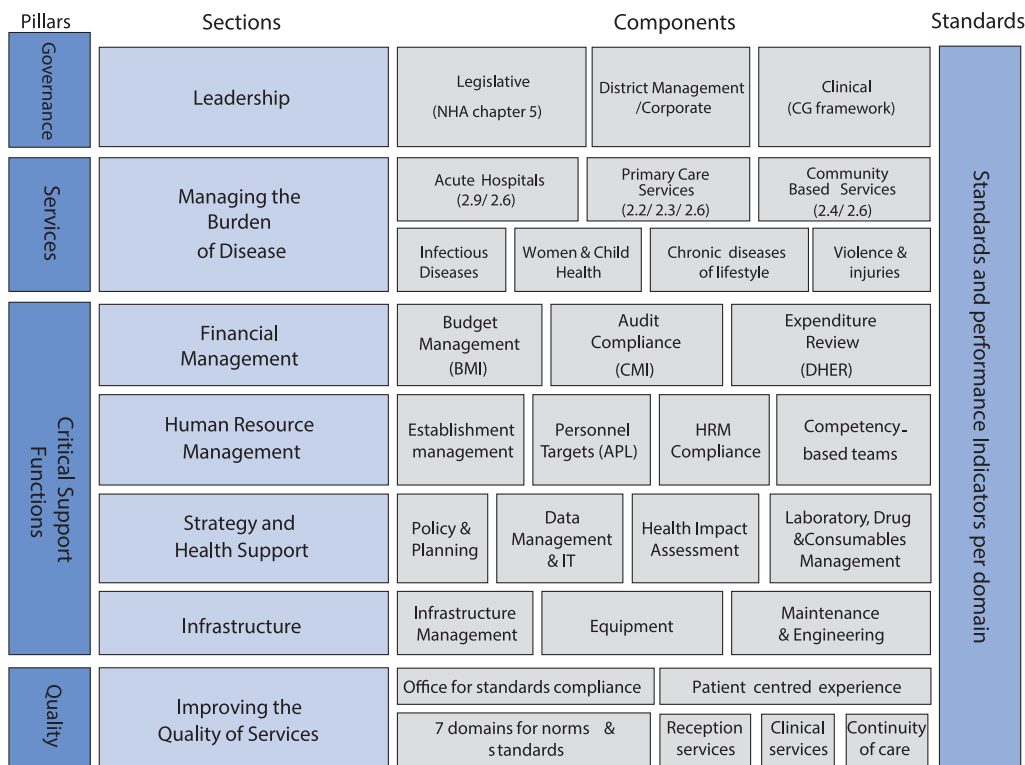
Pillars	Sections	Components			Standards
Governance	Leadership	Legislative (NHA chapter 5)	District Management /Corporate	Clinical (CG framework)	**Standards and performance indicators per domain**
Services	Managing the Burden of Disease	Acute Hospitals (2.9/ 2.6)	Primary Care Services (2.2/ 2.3/ 2.6)	Community Based Services (2.4/ 2.6)	
		Infectious Diseases	Women & Child Health / Chronic diseases of lifestyle	Violence & injuries	
Critical Support Functions	Financial Management	Budget Management (BMI)	Audit Compliance (CMI)	Expenditure Review (DHER)	
	Human Resource Management	Establishment management	Personnel Targets (APL) / HRM Compliance	Competency based teams	
	Strategy and Health Support	Policy & Planning	Data Management & IT / Health Impact Assessment	Laboratory, Drug &Consumables Management	
	Infrastructure	Infrastructure Management	Equipment	Maintenance & Engineering	
Quality	Improving the Quality of Services	Office for standards compliance	Patient centred experience		
		7 domains for norms & standards	Reception services	Clinical services / Continuity of care	

Figure 3: The district management accountability framework.

Strategies used to implement clinical governance

Managers and clinicians in the CWD used various strategies to implement the clinical governance framework, as listed in Box 1.

Box 1: Strategies used to implement clinical governance

1. District clinical governance meetings
2. Focus on clinical governance in existing meetings
3. Create a family physician forum
4. Leadership development
5. Defining clinical governance activities
6. Monitoring and evaluation meetings with a quality improvement focus
7. Developing competent clinical teams
8. PHC-centred approach

The first strategy was to hold a workshop in 2010 to conceptualise the concept of clinical governance within the district and to clarify the roles and responsibilities of the FP. This workshop was facilitated by the head of family medicine at the regional hospital and the district manager. Participants included sub-district managers and district health programme managers, as well as FPs and family medicine registrars. The various components of clinical governance were discussed, as detailed in the provincial framework, together with a need to create a health system that is conducive to quality clinical care and improved patient outcomes. It was concluded that the FP should lead the whole clinical team in an engagement with clinical governance, from the pharmacist to the radiologist, whilst not being seen as the sole executor of clinical governance.

At this initial workshop it was decided to establish six-monthly District Clinical Governance Meetings between managers and

FPs, which would focus on discussion and practical focus areas for implementation of the clinical governance framework and the key role which the FP must play.

> "...for if clinical governance is to be successful it must be underpinned by the same strengths as corporate governance: it must be rigorous in its application, organisation-wide in its emphasis, accountable in its delivery, developmental in its thrust, and positive in its connotations."[2]

During these meetings and whenever planning an improvement cycle, there was a clear distinction made between the changes in clinical practice and services (which would be led by the FP), and the changes in critical support services (which would be led by facility managers, quality assurance managers, or programme managers as a corporate governance issue). Clear lines of responsibility were defined by the district manager.[8] An ongoing focus of these meetings was that FPs should not be overwhelmed with non-clinical duties.

Existing meetings within the district were also used to ensure a continual focus on clinical governance activities:

At the annual district strategic planning workshops, senior managers and FPs developed sub-district clinical governance plans for the year ahead. Plans focused on issues such as improving the efficiency of the emergency centres in district hospitals; developing competencies of medical officers in the management of patients with mental illness and on antiretroviral therapy, and in their surgical, anaesthetic skills and emergency resuscitation skills.

There were also regular sub-district multidisciplinary meetings between the district and sub-district managers, senior clinicians and programme managers, which included specific time for discussing concerns related to the implementation of the sub-district clinical governance plans.

At the initial workshop it was established that there was a need for a Family Physician Forum to be created. The first meeting took place in 2011 and focused on supporting and developing the FPs' function within their workplace as well as sharing their best practices and their challenges in implementing the clinical governance framework within a developing District Health System (DHS). The forum was a platform for sharing best practices and peer learning while remaining accountable to the district manager.

FPs had several roles in the sub-district that included clinical care and consulting with patients referred by other providers, leading clinical governance activities, building capability in the clinical team and supervising junior doctors; interfacing with other specialists and staff in the DHS; supporting community-based services and in some cases, training students.[9] Most of the FPs were newly qualified and struggled to fulfil all these roles, as well as to develop the leadership competencies required. The transition from registrar to FP, in a system that itself was constantly evolving and without an established cadre of experienced FPs to offer guidance, was very challenging. The FP forum provided them with support and a place to 'care for the carers'. The need for support in this transition, leadership development and role clarification was recognised by the Division of Family Medicine and Primary Care at Stellenbosch University, which funded a programme of group and individual coaching for the FPs.

A fourth strategy in implementing the clinical governance framework in the CWD was to assist FPs with developing their roles as clinical leaders, and for sub-district managers to support their leadership by creating an enabling environment for clinical governance, while at the same time ensuring a system of accountability.[2,10] The FP is required both to lead the team and be a part of it, as well as to encourage openness and the ability to learn from mistakes while still holding people accountable for the quality of their care.[11] The managers were to support the FP in their supervisory HR functions of the team of doctors.

The district manager also made the decision to place FP at the district office as part of the district management team (DMT). The purpose of this FP was to act as the interface between sub-district FPs and the district programme managers, ensuring that vertical programmes were implemented and conveyed to clinicians in a manner that encouraged integrated patient care. She offered peer support to the sub-district FPs, whilst supporting the DMT in their understanding of the clinical governance framework, guiding discussions to ensure that strategies were in line with evidence-based guidelines, and assisting in the operationalisation of district strategic plans.

A fifth strategy used in the district when implementing the provincial framework was to identify the many activities that could help measure and improve clinical performance.[12] All these activities had certain features in common: the FP would lead the team; review the identified gap which would form part of a quality improvement cycle; clear distinctions were made between the clinical care issues, which needed to be improved by the FP, versus issues which needed to be addressed by critical support services (see Figure 3).

Audits were one of these activities and addressed the quality of care across the burden of disease in areas such as non-communicable diseases, HIV/AIDS, sexually transmitted infections, tuberculosis, mental health and triage in emergency centres. The interpretation of the findings and formulation of improvement plans was done by the multidisciplinary sub-district team. In addressing the identified gaps the team took cognisance of all the levels of care (see Figure 2) when planning an appropriate intervention.

Other important activities included the monthly sub-district mortality and morbidity meetings,[13] monthly pharmacy and therapeutic meetings, patient folder reviews, and use of laboratory and pharmacy reports from managers to identify outliers, or areas of 'risk' for quality patient care.

Another strategy to assist with risk management and identifying areas for clinical improvement was the regular review of routinely collected indicators at sub-district and district Monitoring and Evaluation (M&E) meetings. These meetings were not only a time for reviewing indicators and whether or not targets were met, but identifying areas that needed improvement, so as to ensure better patient care.

The importance of developing competent clinical teams was seen as another strategy in the clinical governance plan of each sub-district. Ensuring the competence of the doctors in a specific sub-district to deal with the burden of disease, according to the PHC philosophy,[5] was the responsibility of the FP. The development of senior, competent colleagues was a challenge in a rural district with a high turnover of doctors, as occurs in many rural districts.[14]

It was recognised that there were multiple learning opportunities within the DHS such as outreach visits by general specialists from the regional hospitals, rotation of DHS doctors through the regional hospital to develop specific clinical skills (such as anaesthetic skills), district symposiums on a particular topic, training opportunities from the university, as well as learning from journal clubs or academic meetings in a particular sub-district.

A final strategy in implementing the clinical governance framework was to focus on establishing a PHC and not a hospital-centred approach within the district. Sub-district FPs were expected to spend most of their time as clinicians involved in direct service delivery, and through their work in the clinics and district hospitals to permeate a culture of quality improvement and comprehensive care to patients. The support of FPs and other doctors to the PHC facilities in their sub-districts was seen as crucial as most of the consultations in PHC are with nursing staff.[15–17] The importance of ensuring that the time the doctor is at the clinic is used optimally was a resolution for implementation at one of the district clinical governance meetings and a measuring tool was developed to monitor the amount of time spent in the clinics.[18]

Reflection and lessons learnt

The WCGH clinical governance framework was vital in focusing attention on quality improvement, while its implementation required interpretation and experimentation at the district level:

> "The vagueness of the initial definition of clinical governance serves both as a problem and an opportunity, in terms of its successful implementation. It encourages flexibility and local ownership as well as facilitating the organic growth of the process."[12]

The importance of local ownership of the concept of clinical governance, by both the managers and the frontline healthcare

workers, was reflected in the journey taken in the CWD. Some of the lessons learnt in this journey are summarised in Box 2.

Box 2: Lessons learnt when implementing a clinical governance framework

1. Dedicated time in meetings to reflect on implementation of the clinical governance framework
2. Need to clarify the roles and responsibilities of the family physician
3. Need to foster leadership capability
4. Importance of quality improvement cycles
5. Need for tools to monitor the core dimensions of PHC service
6. Care for the carer
7. Clarify the role of the doctor in the PHC clinics

The meeting structures that were created in the CWD aimed to provide dedicated time for reflection:

The aim of an energetic and enthusiastic focus on clinical governance is to encourage a culture where health professionals are able to reflect on how they are working, to envision new possibilities and to find ways to improve the outcomes of their efforts, even in very challenging circumstances.'[6]

'The strength of the working relationship between senior managers and health professionals will be at the heart of successful clinical governance.'[2] In the CWD, the development of this working relationship occurred through discussing issues relating to clinical governance in the meetings mentioned above. For many clinicians, however, there was (and is) an ongoing tension between being in such meetings versus actual clinical care. The district manager's ongoing review of such meetings ensured that the FP's time was mainly spent in meetings that were 'clinically' valuable. These meetings, and the placement of an FP as part of the DMT, have assisted both senior managers and FPs in better understanding the role of the FP and the concept of clinical governance.

Clarifying the roles and responsibilities of the FP was a continual need expressed by both FPs and managers, and many of the strategies mentioned above aimed to clarify clinical versus corporate governance activities, which are both needed to improve care. This need for 'clear lines of accountability for the quality of care' is mentioned in literature.[8]

The issue of fostering leadership capability amongst the FPs and senior managers, as the fourth strategy in implementing a clinical governance framework, has been confirmed in the recently developed WCGH position paper on PHC, which states that 'clinical leadership development will be a critical success factor (for an effective clinical governance system)'.[19] The current framework does not provide explicit guidance on the type of leadership skills required or how these should be practically developed. A collaborative style of leadership will help to develop an organisational culture that welcomes innovation and improvement; motivates people; encourages participation; welcomes questions; sets challenges; encourages the sharing of ideas; and ensures that people learn positively from mistakes.[20] The multiple meetings with different people, and at different levels, could be seen as enabling this type of 'complex adaptive system.'[21]

Audit should not just generate information on performance for higher-level managers, but should form part of a cyclical ongoing quality improvement process,[22] and be part of a learning organisation's culture.[23] If regular audits provide only monitoring information to the DMT then the opportunity to leverage change in clinical practice may be lost. The WCGH clinical governance framework needs to speak more clearly to quality improvement cycles and not just audit.

More needs to be done to develop tools to monitor the quality of care for patients with multi-morbidity. Integrated clinical guidelines, such as the PACK guideline[24] for adult primary care, may help to conceptualise a more integrated and systematic approach to auditing patient care. At present the policy framework states that the provincial coordinating committees for the general speciality disciplines need to standardise the clinical governance tools to be used within each clinical discipline.[5] The risk with this approach is that disease-specific tools are created in a vertical manner by hospital-based specialists for primary care.

The strong focus of the current framework on the technical quality of clinical care for specific conditions within the client–provider consultation may also encourage the development of disease-specific measurements, which may fail to look at the core dimensions of effective PHC services such as issues related to access, continuity of care, coordination of care and comprehensiveness across the lifecycle and from health promotion to palliation. In particular, the patient's experience of the health service as a whole may be lost in this approach to measurement. Recent examples of other tools such as LEAN management[25] to address inefficiencies such as waiting times, and the Primary Care Assessment Tool (PCAT),[26] researched in the CWD, may help to address this imbalance. The CWD has started utilising LEAN management strategies in high-burden facilities to improve the client experience.

The seventh strategy of developing competent clinicians was focused largely on their clinical competence in managing specific diseases (HIV, TB, mental health, non-communicable diseases) and developing acute (surgical and anaesthetic) skills.[27] However, the WCGH clinical governance policy highlights that 'care for the carer' is part of the quality of care framework. Improving the organisational culture to have better communication, more trust, better support and improved relationships is fundamental to increasing staff engagement with their work and improving performance. Primary care groups that value their members will have a system of governance that includes means of identifying and supporting colleagues.[10,28] The coaching project, which formed part of the quarterly FP forum, was one way of creating more resilience amongst the FPs, as well as the district-based FP offering mentoring support to the sub-district FPs. Opportunities for addressing the well-being of all staff were created by enabling access to the Employee Wellness programme available to WCGH staff and encouraging Staff Wellness Days per sub-district.

The final strategy was to continually have a PHC approach with outreach to PHC by doctors. Such an approach is supported by the recent Ideal Clinic[29] initiative, which states that every PHC clinic should have access to a doctor. The role of the primary care doctor, however, should extend beyond just seeing more complicated patients referred by the nurses. Monitoring tools did not measure the quality of the visit, or the knowledge transfer that may have occurred as the doctor mentored the nurses in the clinic. There was less access to doctors in PHC in sub-districts

with a district hospital due to the pull of acute hospital-based care, but district hospitals also reported more appropriate referrals when there was protected time for doctors to perform outreach to PHC. Primary care doctors must use the opportunity to train and support the nurses, and assist with improving clinic management systems.[16] Such a role requires some reorientation and upskilling to conceptualise themselves in this way and to have the competencies required. A recent national project has developed a national Diploma in Family Medicine that is aimed at equipping primary care doctors for these roles.[17]

Conclusion and recommendations

The implementation of the WCGH clinical governance framework in the newly formed CWD has provided insights into appropriate structures and effective strategies. Activities should take place within a supportive organisational culture with a focus on continuous quality improvement at the sub-district, facility and community level. An effort should be made to balance a systematic approach to planning clinical governance at the district level, with a localised approach to encouraging reflection, engagement and change.

Ideally, the district should have a comprehensive approach to clinical governance activities to ensure (i) that all key dimensions of systems performance are looked at such as access, continuity, coordination, comprehensiveness,[1] (ii) that the key conditions and clinical processes are all addressed across the whole spectrum of disease, and (iii) that both the patient's perspective and the health professional perspective is incorporated. Finally, the whole plan must be designed to be sustainable and implementable within current resources.

Amongst the lessons learnt are some recommendations for changes to the existing framework, many of which are in line with the recently distributed WCGH PHC position paper.

Future focus areas are to review the role of all health providers within the health system in ensuring clinical governance; to assess how to measure the impact of the clinical governance framework;[9,30] to put in place specific strategies to improve the data on individual health care activities;[2,31] to explore the role of the community in assisting with clinical governance; and how a more collaborative approach can be taken between provider, client and community when wanting to improve care.

They declare that they have no financial or personal relationship(s) which many have inappropriately influenced them in writing this paper.

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